Complete Summary

GUIDELINE TITLE

Guideline on behavior guidance for the pediatric dental patient.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatric Dentistry Clinical Affairs Committee-Behavior, American Academy of Pediatric Dentistry Council on Clinical Affairs. Guideline on behavior guidance for the pediatric dental patient. Pediatr Dent 2008-2009;30(7 Suppl):125-33. [63 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Academy of Pediatric Dentistry (AAPD). Guideline on behavior guidance for the pediatric dental patient. Chicago (IL): American Academy of Pediatric Dentistry (AAPD); 2006. 9 p. [62 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Pediatric dental diseases
- Fear, anxiety, or inappropriate behavior during dental procedures

GUIDELINE CATEGORY

Counseling
Management
Prevention
Risk Assessment
Treatment

CLINICAL SPECIALTY

Dentistry
Pediatrics

INTENDED USERS

Allied Health Personnel
Dentists
Health Care Providers
Nurses
Patients
Physicians

GUIDELINE OBJECTIVE(S)

To educate health care providers, parents, and other interested parties about many behavior guidance techniques used in contemporary pediatric dentistry

TARGET POPULATION

Infants, children, adolescents and persons with special health care needs undergoing dental procedures

INTERVENTIONS AND PRACTICES CONSIDERED

Behavior Guidance Techniques

1. Obtaining informed consent
2. Patient communication
3. Tell-show-do technique
4. Voice control
5. Nonverbal communication
6. Positive reinforcement
7. Distraction
8. Parental presence/absence
9. Nitrous oxide/oxygen inhalation
10. Protective stabilization
11. Sedation
12. General anesthesia

MAJOR OUTCOMES CONSIDERED

- Co-operative patient behavior
- Patient satisfaction

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

This guideline was developed following the American Academy of Pediatric Dentistry (AAPD)'s 1989 consensus conference on behavior management for the pediatric dental patient. In 2003, the AAPD held another symposium on behavior guidance, with proceedings published in Pediatric Dentistry (2004, Vol. 26, No. 2). This revision reflects a review of those proceedings, other dental and medical literature related to behavior guidance of the pediatric patient, and sources of recognized professional expertise and stature including both the academic and practicing pediatric dental communities and the standards of the Commission on Dental Accreditation. MEDLINE searches were performed using key terms such as "behavior management in children", "behavior management in dentistry", "child behavior and dentistry", "child and dental anxiety", "child preschool and dental anxiety", "child personality and test", "child preschool personality and test", "patient cooperation", "dentists and personality", "dentist-patient relations", "patient assessment", "treatment deferral", and "restraint".

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Consensus Development Conference)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Clinical guidelines of the American Academy of Pediatric Dentistry (AAPD) are developed under the direction of the Board of Trustees, utilizing the resources and expertise of its membership operating through the Council on Clinical Affairs (CCA).

Proposals to develop or modify guidelines may originate from 4 sources:

1. The officers or trustees acting at any meeting of the Board of Trustees
2. A council, committee, or task force in its report to the Board of Trustees
3. Any member of the AAPD acting through the Reference Committee hearing of the General Assembly at the Annual Session
4. Officers, trustees, council and committee chairs, or other participants at the AAPD's Annual Strategic Planning Session

Regardless of the source, proposals are considered carefully, and those deemed sufficiently meritorious by a majority vote of the Board of Trustees are referred to the CCA for development or review/revision.

Once a charge (directive from the Board of Trustees) for development or review/revision of a clinical guideline is sent to the CCA, it is assigned to 1 or more members of the CCA for completion. CCA members are instructed to follow the specified format for a guideline. All clinical guidelines are based on 2 sources of evidence: (1) the scientific literature; and (2) experts in the field. Members may call upon any expert as a consultant to the council to provide expert opinion. The Council on Scientific Affairs provides input as to the scientific validity of a guideline.

The CCA meets on an interim basis (midwinter) to discuss proposed clinical guidelines. Each new or reviewed/revised guideline is reviewed, discussed, and confirmed by the entire council.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Once developed by the Council on Clinical Affairs (CCA), the proposed guideline is submitted for the consideration of the Board of Trustees. While the board may request revision, in which case it is returned to the council for modification, once accepted by majority vote of the board, it is referred for Reference Committee hearing at the upcoming Annual Session. At the Reference Committee hearing,

the membership may provide comment or suggestion for alteration of the document before presentation to the General Assembly. The final document then is presented for ratification by a majority vote of the membership present and voting at the General Assembly. If accepted by the General Assembly, either as proposed or as amended by that body, the document then becomes the official American Academy of Pediatric Dentistry (AAPD) clinical guideline for publication in the AAPD's Reference Manual and on the AAPD's Web site.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Background Summary

1. Behavior guidance is based on scientific principles. The proper implementation of behavior guidance requires an understanding of these principles. Behavior guidance, however, is more than pure science and requires skills in communication, empathy, coaching, and listening. As such, behavior guidance is a clinical art form and skill built on a foundation of science.
2. The goals of behavior guidance are to establish communication, alleviate fear and anxiety, deliver quality dental care, build a trusting relationship between dentist and child, and promote the child's positive attitude towards oral/dental health and oral health care.
3. The urgency of the child's dental needs must be considered when planning treatment. Deferral or modification of treatment sometimes may be appropriate until routine care can be provided using appropriate behavior guidance techniques.
4. All decisions regarding use of behavior guidance techniques must be based upon a benefit vs. risk evaluation. As part of the process of obtaining informed consent, the dentist's recommendations regarding use of techniques (other than communicative guidance) must be explained to the parent's understanding and acceptance. Parents share in the decision-making process regarding treatment of their children.
5. The dental staff must be trained carefully to support the doctor's efforts and properly welcome the patient and parent into a child-friendly environment that will facilitate behavior guidance and a positive dental visit.

Basic Behavior Guidance

Communication and Communicative Guidance

Communicative management and appropriate use of commands are used universally in pediatric dentistry with both the cooperative and uncooperative child. In addition to establishing a relationship with the child and allowing for the successful completion of dental procedures, these techniques may help the child develop a positive attitude toward oral health. Communicative management comprises a host of techniques that, when integrated, enhance the evolution of a cooperative patient. Rather than being a collection of singular techniques, communicative management is an ongoing subjective process that becomes an extension of the personality of the dentist. Associated with this process are the specific techniques of tell-show-do, voice control, nonverbal communication,

positive reinforcement, and distraction. The dentist should consider the cognitive development of the patient, as well as the presence of other communication deficits (e.g., hearing disorder), when choosing specific communicative management techniques.

Tell-Show-Do

- Description: Tell-show-do is a technique of behavior shaping used by many pediatric professionals. The technique involves verbal explanations of procedures in phrases appropriate to the developmental level of the patient (tell); demonstrations for the patient of the visual, auditory, olfactory, and tactile aspects of the procedure in a carefully defined, non-threatening setting (show); and then, without deviating from the explanation and demonstration, completion of the procedure (do). The tell-show-do technique is used with communication skills (verbal and nonverbal) and positive reinforcement.
- Objectives: The objectives of the tell-show-do are to:
    1. Teach the patient important aspects of the dental visit and familiarize the patient with the dental setting
    2. Shape the patient's response to procedures through desensitization and well-described expectations
- Indications: May be used with any patient
- Contraindications: None

Voice Control

- Description: Voice control is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior. Parents unfamiliar with this technique may benefit from an explanation prior to its use to prevent misunderstanding.
- Objectives: The objectives of voice control are to:
    1. Gain the patient's attention and compliance
    2. Avert negative or avoidance behavior
    3. Establish appropriate adult-child roles
- Indications: May be used with any patient
- Contraindications: Patients who are hearing impaired

Nonverbal Communication

- Description: Nonverbal communication is the reinforcement and guidance of behavior through appropriate contact, posture, facial expression and body language.
- Objectives: The objectives of nonverbal communication are to:
    1. Enhance the effectiveness of other communicative management techniques
    2. Gain or maintain the patient's attention and compliance
- Indications: May be used with any patient
- Contraindications: None

Positive Reinforcement

- Description: In the process of establishing desirable patient behavior, it is essential to give appropriate feedback. Positive reinforcement is an effective

technique to reward desired behaviors and, thus, strengthen the recurrence of those behaviors. Social reinforcers include positive voice modulation, facial expression, verbal praise, and appropriate physical demonstrations of affection by all members of the dental team. Nonsocial reinforcers include tokens and toys.

- Objective: To reinforce desired behavior
- Indications: May be useful for any patient
- Contraindications: None

Distraction

- Description: Distraction is the technique of diverting the patient's attention from what may be perceived as an unpleasant procedure. Giving the patient a short break during a stressful procedure can be an effective use of distraction prior to considering more advanced behavior guidance techniques.
- Objectives: The objectives of distraction are to:
    1. Decrease the perception of unpleasantness
    2. Avert negative or avoidance behavior
- Indications: May be used with any patient
- Contraindications: None

Parental Presence/Absence

- Description: The presence or absence of the parent sometimes can be used to gain cooperation for treatment. A wide diversity exists in practitioner philosophy and parental attitude regarding parents' presence or absence during pediatric dental treatment.

  Parenting styles in America have evolved in recent decades. Practitioners are faced with challenges from an increasing number of children who many times are ill-equipped with the coping skills and self-discipline necessary to deal with new experiences in the dental office. Frequently, parental expectations for the child's behavior are unrealistic, while expectations for the dentist who guides their behavior are great.

  Practitioners agree that good communication is important among the dentist, patient, and parent. Practitioners also are united in the fact that effective communication between the dentist and the child is paramount and requires focus on the part of both parties. Children's responses to their parents' presence or absence can range from very beneficial to very detrimental. Each practitioner has the responsibility to determine the communication and support methods that best optimize the treatment setting recognizing his/her own skills, the abilities of the particular child, and the desires of the specific parent involved.

- Objectives: The objectives of parental presence/absence are to:
    1. Gain the patient's attention and improve compliance
    2. Avert negative or avoidance behaviors
    3. Establish appropriate dentist-child roles
    4. Enhance effective communication among the dentist, child, and parent
    5. Minimize anxiety and achieve a positive dental experience
- Indications: May be used with any patient

- Contraindications: Parents who are unwilling or unable to extend effective support (when asked)

Nitrous Oxide/Oxygen Inhalation

- Description: Nitrous oxide/oxygen inhalation is a safe and effective technique to reduce anxiety and enhance effective communication. Its onset of action is rapid, the effects easily are titrated and reversible, and recovery is rapid and complete. Additionally, nitrous oxide/oxygen inhalation mediates a variable degree of analgesia, amnesia, and gag reflex reduction.

  The need to diagnose and treat, as well as the safety of the patient and practitioner, should be considered before the use of nitrous oxide/oxygen analgesia/anxiolysis. Detailed information concerning the indications, contraindications, and additional clinical considerations may be found in the National Guideline Clearinghouse (NGC) summary of the American Academy of Pediatric Dentistry's (AAPD) Clinical Guideline on Appropriate Use of Nitrous Oxide for Pediatric Dental Patients.

Advanced Behavior Guidance

Most children can be managed effectively using the techniques outlined in basic behavior guidance. These basic behavior guidance techniques should form the foundation for all of the management activities provided by the dentist. Children, however, occasionally present with behavioral considerations that require more advanced techniques. The advanced behavior guidance techniques commonly used and taught in advanced pediatric dental training programs include protective stabilization, sedation, and general anesthesia. They are extensions of the overall behavior guidance continuum with the intent to facilitate the goals of communication, cooperation, and delivery of quality oral health care in the difficult patient. Appropriate diagnosis of behavior and safe and effective implementation of these techniques necessitate knowledge and experience that are generally beyond the core knowledge students receive during predoctoral dental education. While most predoctoral programs provide didactic exposure to treatment of very young children (i.e., aged birth – 2 years), patients with special health care needs, and advanced behavior guidance techniques, hands-on experience is lacking. A minority of programs provides educational experiences with these patient populations, while few provide hands-on exposure to advanced behavior guidance techniques. Dentists considering the use of these advanced behavior guidance techniques should seek additional training through a residency program, a graduate program, and/or an extensive continuing education course that involves both didactic and experiential mentored training.

Protective Stabilization

- Description: The use of any type of protective stabilization in the treatment of infants, children, adolescents, or persons with special health care needs is a topic that concerns healthcare providers, care givers, and the public. The broad definition of protective stabilization is the restriction of patient's freedom of movement, with or without the patient's permission, to decrease risk of injury while allowing safe completion of treatment. The restriction may involve another human(s), a patient stabilization device, or a combination

thereof. The use of protective stabilization has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, and violation of a patient's rights. Stabilization devices placed around the chest may restrict respirations; they must be used with caution, especially for patients with respiratory compromise (e.g., asthma) and/or who will receive medications (i.e., local anesthetics, sedatives) that can depress respirations. Because of the associated risks and possible consequences of use, the dentist is encouraged to evaluate thoroughly its use on each patient and possible alternatives. Careful, continuous monitoring of the patient is mandatory during protective stabilization.

Partial or complete stabilization of the patient sometimes is necessary to protect the patient, practitioner, staff, or the parent from injury while providing dental care. Protective stabilization can be performed by the dentist, staff, or parent with or without the aid of a restrictive device. The dentist always should use the least restrictive, but safe and effective, protective stabilization. The use of a mouth prop in a compliant child is not considered protective stabilization.

The need to diagnose, treat, and protect the safety of the patient, practitioner, staff, and parent should be considered for the use of protective stabilization. The decision to use patient stabilization should take into consideration:

1. Alternate behavior guidance modalities
2. Dental needs of the patient
3. The effect on the quality of dental care
4. The patient's emotional development
5. The patient's emotional and physical considerations

Protective stabilization, with or without a restrictive device, performed by the dental team requires informed consent from a parent. Informed consent must be obtained and documented in the patient's record prior to use of protective stabilization. Due to the possible aversive nature of the technique, informed consent also should be obtained prior to a parent's performing protective stabilization during dental procedures. Furthermore, when appropriate, an explanation to the patient regarding the need for restraint, with an opportunity for the patient to respond, should occur.

In the event of an unanticipated reaction to dental treatment, it is incumbent upon the practitioner to protect the patient and staff from harm. Following immediate intervention to assure safety, if techniques must be altered to continue delivery of care, the dentist must have informed consent for the alternative methods.

The patient's record must include:

1. Informed consent for stabilization
2. Indication for stabilization
3. Type of stabilization
4. The duration of application of stabilization
5. Behavior evaluation/rating during stabilization

- Objectives: The objectives of patient stabilization are to:
    1. Reduce or eliminate untoward movement
    2. Protect patient, staff, dentist, or parent from injury
    3. Facilitate delivery of quality dental treatment
- Indications: Patient stabilization is indicated when:

    1. Patients require immediate diagnosis and/or limited treatment and cannot cooperate due to lack of maturity or mental or physical disability
    2. The safety of the patient, staff, dentist, or parent would be at risk without the use of protective stabilization
    3. Sedated patients require limited stabilization to help reduce untoward movement
- Contraindications: Patient stabilization is contraindicated for:

    1. Cooperative non-sedated patients
    2. Patients who cannot be immobilized safely due to associated medical or physical conditions
    3. Patients who have experienced previous physical or psychological trauma from protective stabilization (unless no other alternatives are available)
    4. Nonsedated patients with nonemergent treatment requiring lengthy appointments
- Precautions: The following precautions should be taken prior to patient stabilization:

    1. Careful review of the patient's medical history to ascertain if there are any medical conditions e.g., asthma) which may compromise respiratory function
    2. Tightness and duration of the stabilization must be monitored and reassessed at regular intervals
    3. Stabilization around extremities or the chest must not actively restrict circulation or respiration
    4. Stabilization should be terminated as soon as possible in a patient who is experiencing severe stress or hysterics to prevent possible physical or psychological trauma

Sedation

- Description: Sedation can be used safely and effectively with patients unable to receive dental care for reasons of age or mental, physical, or medical condition. Background information and documentation for the use of sedation is detailed in the NGC summary of the AAPD's Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

    The need to diagnose and treat, as well as the safety of the patient, practitioner, and staff, should be considered for the use of sedation. The decision to use sedation must take into consideration:

    1. Alternative behavioral guidance modalities
    2. Dental needs of the patient

3. The effect on the quality of dental care
4. The patient's emotional development
5. The patient's physical considerations

Documentation shall include: (See the NGC summary of the AAPD's Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures).

1. Informed consent. Informed consent must be obtained from the parent and documented prior to the use of sedation
2. Instructions and information provided to the parent
3. Health evaluation
4. A time-based record that includes the name, route, site, time, dosage, and patient effect of administered drugs
5. The patient's level of consciousness, responsiveness, heart rate, blood pressure, respiratory rate, and oxygen saturation at the time of treatment and until predetermined discharge criteria have been attained
6. Adverse events (if any) and their treatment
7. Time and condition of the patient at discharge

- Objectives: The goals of sedation are to:
  1. Guard the patient's safety and welfare
  2. Minimize physical discomfort and pain
  3. Control anxiety, minimize psychological trauma, and maximize the potential for amnesia
  4. Control behavior and/or movement so as to allow the safe completion of the procedure
  5. Return the patient to a state in which safe discharge from medical supervision, as determined by recognized criteria, is possible
- Indications: Sedation is indicated for:

  1. Fearful, anxious patients for whom basic behavior guidance techniques have not been successful
  2. Patients who cannot cooperate due to a lack of psychological or emotional maturity and/or mental, physical, or medical disability
  3. Patients for whom the use of sedation may protect the developing psyche and/or reduce medical risk
- Contraindications: The use of sedation is contraindicated for:

  1. The cooperative patient with minimal dental needs
  2. Predisposing medical conditions which would make sedation inadvisable

General Anesthesia

- Description: General anesthesia is a controlled state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. The use of general anesthesia sometimes is necessary to provide quality dental care for the child. Depending on the patient, this can be done in a hospital or an ambulatory setting, including the dental office.

Additional background information may be found in the American Academy of Pediatric Dentistry's Clinical *Guideline on Use of Anesthesia Care Providers in the Administration of In-office Deep Sedation/General Anesthesia to the Pediatric Dental Patient*.

The need to diagnose and treat, as well as the safety of the patient, practitioner, and staff, should be considered for the use of general anesthesia. The decision to use general anesthesia must take into consideration:

1. Alternative behavioral guidance modalities
2. Dental needs of the patient
3. The effect on the quality of dental care
4. The patient's emotional development
5. The patient's medical status

Prior to the delivery of general anesthesia, appropriate documentation shall address the rationale for use of general anesthesia, informed consent, instructions provided to the parent, dietary precautions, and preoperative health evaluation. Because laws and codes vary from state to state, minimal requirements for a time-based anesthesia record should include:

1. The patient's heart rate, blood pressure, respiratory rate, and oxygen saturation at specific intervals throughout the procedure and until predetermined discharge criteria have been attained
2. The name, route, site, time, dosage, and patient effect of administered drugs, including local anesthesia
3. Adverse events (if any) and their treatment
4. That discharge criteria have been met, the time and condition of the patient at discharge, and into whose care the discharge occurred

- Objectives: The goals of general anesthesia are to:
    1. Provide safe, efficient, and effective dental care
    2. Eliminate anxiety
    3. Reduce untoward movement and reaction to dental treatment
    4. Aid in treatment of the mentally, physically, or medically compromised patient
    5. Eliminate the patient's pain response
- Indications: General anesthesia is indicated for:

    1. Patients who cannot cooperate due to a lack of psychological or emotional maturity and/or mental, physical, or medical disability
    2. Patients for whom local anesthesia is ineffective because of acute infection, anatomic variations, or allergy
    3. The extremely uncooperative, fearful, anxious, or uncommunicative child or adolescent
    4. Patients requiring significant surgical procedures
    5. Patients for whom the use of general anesthesia may protect the developing psyche and/or reduce medical risk
    6. Patients requiring immediate, comprehensive oral/dental care
- Contraindications: The use of general anesthesia is contraindicated for:

    1. A healthy, cooperative patient with minimal dental needs

2. Predisposing medical conditions which would make general anesthesia inadvisable

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

All clinical guidelines are based on 2 sources of evidence: (1) the scientific literature; and (2) experts in the field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Reduction in pain and anxiety of pediatric dental patients with special health care needs
- Increase in safety and quality of care for pediatric dental patients
- Increase in safety of dental staff

POTENTIAL HARMS

The use of protective stabilization has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, and violation of a patient's rights.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Parental presence is contraindicated when parents are unwilling or unable to extend effective support (when asked).
- Voice control techniques are contraindicated in patients who are hearing impaired.
- Patient stabilization is contraindicated for:
    - Cooperative nonsedated patients
    - Patients who cannot be immobilized safely due to associated medical or physical conditions
    - Patients who have experienced previous physical or psychological trauma from protective stabilization (unless no other alternatives are available)
    - Nonsedated patients with nonemergent treatment requiring lengthy appointments
- The use of sedation is contraindicated for:
    - The cooperative patient with minimal dental needs
    - Predisposing medical conditions which would make sedation inadvisable

- The use of general anesthesia is contraindicated for:
    - A healthy, cooperative patient with minimal dental needs
    - Predisposing medical conditions which would make general anesthesia inadvisable

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The American Academy of Pediatric Dentistry (AAPD) recognizes that, in providing oral health care for infants, children, adolescents, and persons with special health care needs, a continuum of both nonpharmacological and pharmacological behavior guidance techniques may be used by dental health care providers. The various behavior guidance techniques used must be tailored to the individual patient and practitioner. Promoting a positive dental attitude, safety, and quality of care are of the utmost importance. This guideline is intended to educate health care providers, parents, and other interested parties about many behavior guidance techniques used in contemporary pediatric dentistry. It will not attempt to duplicate information found in greater detail in the AAPD's *Clinical Guideline on Appropriate Use of Nitrous Oxide for Pediatric Dental Patients*, *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update*, and *Clinical Guideline on the Use of Anesthesia Care Providers in the Administration of In-office Deep Sedation/General Anesthesia to the Pediatric Dental Patient*.
- Some of the behavior guidance techniques in this document are intended to maintain communication, while others are intended to extinguish inappropriate behavior and establish communication. As such, these techniques cannot be evaluated on an individual basis as to validity, but must be assessed within the context of the child's total dental experience. Each technique must be integrated into an overall behavior guidance approach individualized for each child. Therefore, behavior guidance is as much an art as it is a science. It is not an application of individual techniques created to "deal" with children, but rather a comprehensive, continuous method meant to develop and nurture the relationship between patient and doctor, which ultimately builds trust and allays fear and anxiety.
- Dentists are encouraged to utilize behavior guidance techniques consistent with their level of professional education and clinical experience. Behavior guidance cases that are beyond the training, experience, and expertise of individual practitioners should be referred to practitioners who can render care more appropriately.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatric Dentistry Clinical Affairs Committee-Behavior, American Academy of Pediatric Dentistry Council on Clinical Affairs. Guideline on behavior guidance for the pediatric dental patient. Pediatr Dent 2008-2009;30(7 Suppl):125-33. [63 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2000 (revised 2008)

GUIDELINE DEVELOPER(S)

American Academy of Pediatric Dentistry - Professional Association

SOURCE(S) OF FUNDING

American Academy of Pediatric Dentistry

GUIDELINE COMMITTEE

Clinical Affairs Committee – Behavior Management Subcommittee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Council members and consultants derive no financial compensation from the American Academy of Pediatric Dentistry (AAPD) for their participation and are asked to disclose potential conflicts of interest.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Academy of Pediatric Dentistry (AAPD). Guideline on behavior guidance for the pediatric dental patient. Chicago (IL): American Academy of Pediatric Dentistry (AAPD); 2006. 9 p. [62 references]

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Academy of Pediatric Dentistry Web site.

Print copies: Available from the American Academy of Pediatric Dentistry, 211 East Chicago Avenue, Suite 700, Chicago, Illinois 60611.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Overview. American Academy of Pediatric Dentistry 2007-08 definitions, oral health policies, and clinical guidelines. Available from the American Academy of Pediatric Dentistry Web site.
- Sedation record. Available in Portable Document Format (PDF) from the American Academy of Pediatric Dentistry Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on August 18, 2005. This NGC summary was updated by ECRI Institute on August 6, 2007. The updated information was verified by the guideline developer on August 23, 2007. This NGC summary was updated by ECRI Institute on June 10, 2009. The updated information was verified by the guideline developer on July 14, 2009.

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Date Modified: 8/10/2009